

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

4 5

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												9 22841		
												REG. NO.		
1 - FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			20. DATE OF DEATH MONTH DAY YEAR			26 HOUR		
			<i>Jacob ALBERT Bair BAIR</i>						09 27 79			1:35 AM		
2. SEX		3. RACE		4. DATE OF BIRTH MONTH DAY YEAR			5. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.							
Male		White		12 17 1918			60 YRS.							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH							
Pa.		U.S.A.					Howard County MD.							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
Columbia, Md.		Howard County General		Soc Sec. Adm.										
13a. STATE 13b. COUNTY 13c. CITY OR TOWN												13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
Md. Howard Elliott City												13e. STREET ADDRESS <i>Town & Country, Apt. S, Rogers Ave. - Elliott City</i>		
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) 16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS						
Grover C. Bair		Kathryn Longenecker			yes WWII 177-10-1015 Mrs. Mary S. Baker McClure Pa			17841						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiorespiratory arrest</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Acute pulmonary edema</i> DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 1/2 hrs.</i>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Diabetes mellitus</i>														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY				
22a. I certify that (I) (this hospital) attended the deceased from <i>11 PM 26 Sept 1979</i> , to <i>1:35 AM 27 Sept 1979</i> , that (I) (we) last saw the deceased alive on <i>27 Sept. 1979</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.												22c. DATE SIGNED <i>9/27/79</i>		
22b. SIGNATURE <i>M. Stahl, M.D.</i>		22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>A. G. Stahl, m.s.</i>			22e. DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE <i>Cremation 9-28-79</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Wilwood Crematory</i>			23d. LOCATION CITY OR TOWN <i>Williamsport, Lycoming Co., Pa.</i>			23e. COUNTY				
24. FUNERAL DIRECTOR NAME <i>SLACK Funeral Home, Ellicott City, Maryland 21043</i>		25a. DATE REC'D. BY REGISTRAR <i>OCT 6 1979</i>			25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>									



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IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												7 9 2 2 8 4 2			
												REG. NO.			
1. FOR STATE REGISTRAR	1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR		
	<i>SAMUEL D. BRIGHT SR</i>					<i>SAMUEL D. BRIGHT SR</i>	<i>9 23 79</i>						<i>3:45 P.M.</i>		
3. SEX	4 RACE	5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR			IF UNDER 24 HRS.				
<i>M</i>	<i>BLACK</i>	<i>MAY 13 1894</i>			<i>85</i>			YEARS			MONTHS DAYS HOURS MIN				
7a. BIRTHPLACE COUNTRY	7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.					
<i>Md.</i>	<i>U.S.A.</i>						<i>HOWARD</i>								
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY								
<i>Columbia</i>	<i>LORIEN Nursing Home</i>			<i>LABORER</i>			<i>Construction</i>								
13a. STATE	13b. COUNTY	13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS							
<i>Md.</i>	<i>HOWARD</i>	<i>Columbia</i>						<i>7080 Cradlerock Way</i>							
14. FATHER'S NAME	FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME											
	<i>Phillip</i>	<i>BRIGHT</i>		<i>Elizabeth GILES</i>											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR GATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT			ADDRESS			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
<i>NO</i>	<i>218-05-1119</i>	<i>Florence BRIGHT (wife) same as #13</i>													
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Malnutrition Color</i> .															
1539 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)															
DUE TO, OR AS A CONSEQUENCE OF (c)															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Alimentary tract infection; brewing; Delirium</i>															
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?								
				<input type="checkbox"/> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			<input type="checkbox"/> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <i>9-16 1979</i> , to <i>9-23 1979</i> , that (I) (we) last saw the deceased alive on <i>9-23 1979</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												22c. DATE SIGNED <i>9-23-79</i>			
22b. SIGNATURE <i>A. P. Lewis</i>	22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>A. P. Lewis M.D.</i>			22e. ADDRESS <i>5216 Lynn Lane Rd. Columbia, Md. 21044</i>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE <i>9-28-79</i>	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <i>Brown's Chapel Cen. 346 N. Wash. St.</i>			23d. LOCATION CITY OR TOWN <i>Dayton Howard Md.</i>			COUNTY			STATE				
24. FUNERAL DIRECTOR NAME <i>George R. Snowden Rockville, Md.</i>	25a. DATE REC'D. BY REGISTRAR <i>SEP 27 1979</i>			25b. REGISTRAR'S SIGNATURE <i>George R. Snowden</i>											

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IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO.								
1. FOR STATE REGISTRAR			I. DECEASED NAME . FIRST			MIDDLE			LAST			2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR				
			<i>Doris Maryanne Cavey</i>									<i>09</i>	<i>05</i>	<i>79</i>	<i>9:32 PM</i>					
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS.						
<i>F</i>			<i>B</i>			MONTH <i>03</i> DAY <i>28</i> YEAR <i>1934</i>			<i>55</i>			MONTHS		DAYS		HOURS MIN.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8			MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH								
<i>Mass.</i>			<i>U.S.A.</i>									<i>Howard</i>								
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY											
<i>Columbia</i>			<i>Howard City Gen. Hosp</i>						<i>Housewife</i>											
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS								
<i>Md.</i>			<i>Howard</i>			<i>Ellicott City</i>						<i>9734 Old Annapolis Rd.</i>								
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME																	
FIRST <i>late Cyprian Morisette</i>			LAST																	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS											
<i>No</i>			<i>014 20 9552</i>			<i>Joseph Cavey</i>			<i>9734 Old Annapolis Rd</i>											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
<i>4254</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												DUE TO, OR AS A CONSEQUENCE OF (b) <i>Cardio myopathy, CHF, Ventricular Fibrillation</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Pulmonary Tuberculosis</i>								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																				
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?											
									YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)														
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY		STATE						
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <i>3/21/79</i> , to <i>3/21/79</i> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <i>3/21/79</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death.																				
22b. SIGNATURE <i>Rufael</i>			22c. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED <i>9/6/79</i>											
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>RUFael</i>			22e. ADDRESS <i>Columbia Med Plan</i>																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			COUNTY		STATE						
Burial			<i>Sept 8 '79</i>			<i>St Louis</i>			<i>Clarksville, Howard, Maryland</i>											
24. FUNERAL DIRECTOR NAME			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE														
<i>Harry H. Witzke 4112 Columbia Rd Ellicott City</i>			<i>SEP 13 1979</i>																	



SECRET//NOFORN//~~REF ID: A651470~~

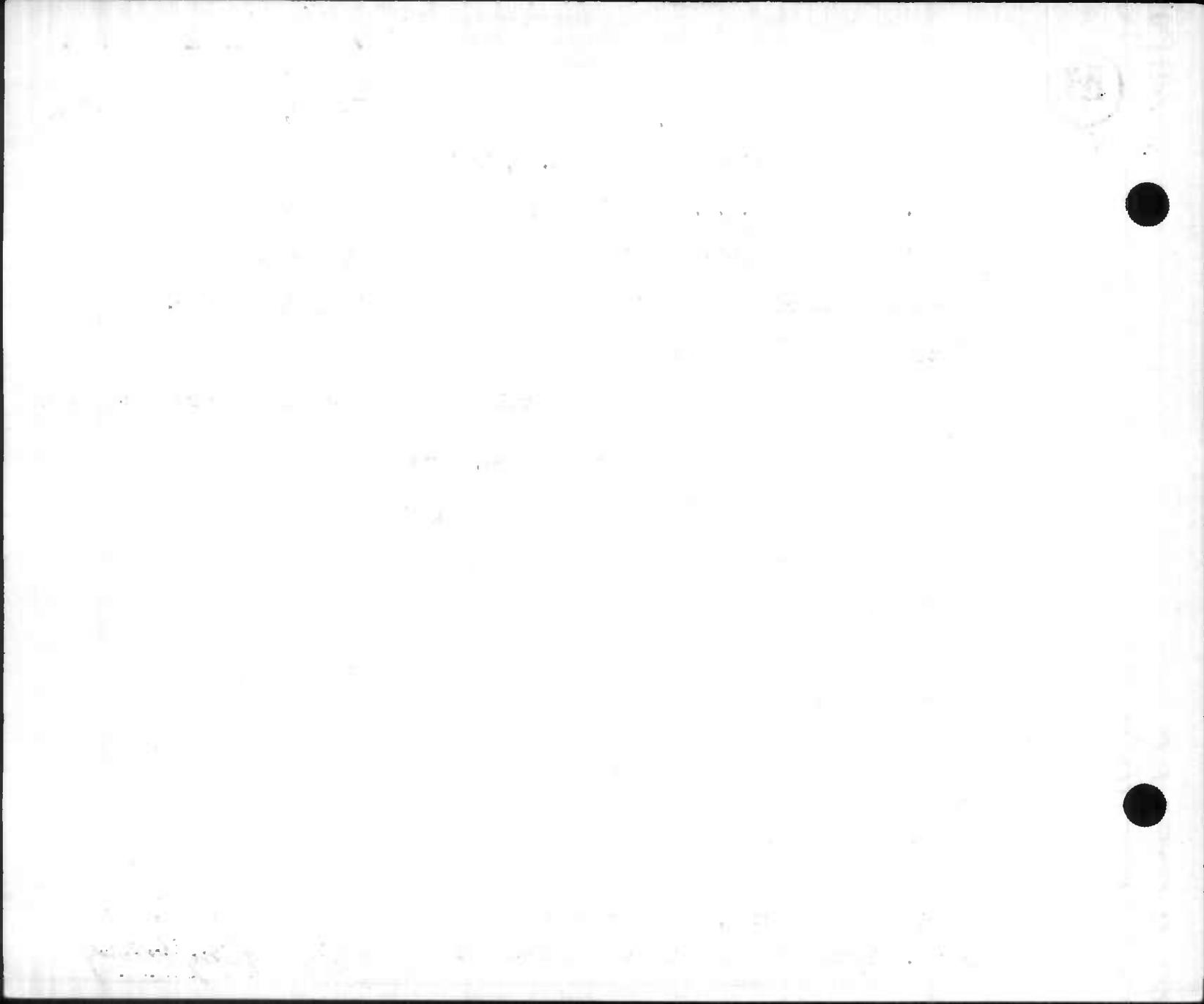
BY STAFFORD BROWN, JR. 100-11470

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death... Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 7 9 2 2 8 4 4		
1 - STATE REGISTRAR			1a. DECEASED NAME (TYPE OR PRINT)				1b. FIRST MIDDLE LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
			SOPHIE COURSON						Sept 29, 1979		5:30 AM	
3. SEX <i>Male</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>Oct. 9, 1892</i>		6. AGE (IN YEARS LAST BIRTHDAY) YRS <i>86</i>		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Conn.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MD. <i>Howard</i>						
10. CITY OR TOWN OF DEATH <i>Columbia</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Lorien Nursing Home</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY						
13a. STATE <i>Maryland</i>		13b. COUNTY <i>Howard</i>		13c. CITY OR TOWN <i>Columbia</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <i>5025 Castlemoor Dr.</i>				
14. FATHER'S NAME FIRST <i>late</i>		MIDDLE <i>S. mon</i>		LAST		15. MOTHER'S MAIDEN NAME FIRST <i></i>		MIDDLE <i></i>		LAST <i></i>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO		17. INFORMANT		ADDRESS						
				Paul S Courson Jr		3211 Evergreen Way 21043						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>ASCVD</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH												
4292 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (1) this hospital attended the deceased from <i>3-22 1961</i> to <i>9-29 1979</i> , that (2) (we) last saw the deceased alive on <i>9-28 1979</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <i>Peter V. Thorpe</i>		DEGREE <i>M.D.</i>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>10-1-79</i>						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Peter V. Thorpe, M.D.</i>		22e. ADDRESS <i>3459 St. Johns Lane Ellicott City, Md.</i>										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>Oct 2, 1979</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Crestlawn</i>		23d. LOCATION CITY OR TOWN <i>Howard, Maryland</i>						
24. FUNERAL DIRECTOR <i>Harry H. Witzke 4112 Columbia Road Ellicott City</i>		25a. DATE REC'D. BY REGISTRAR <i>OCT 3 1979</i>		25b. REGISTRAR'S SIGNATURE <i>Harry H. Witzke</i>								



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1- STATE
REGISTRAR2 2 3 4 5
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE KNOWN OF ESTI- DEATH MATED	MONTH	DAY	YEAR	2b. HOUR	
		Angelo	Joseph	Fortunato	<input checked="" type="checkbox"/>	9	3	19	79 M	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE IN YEARS LAST BIRTHDAY	7. IF UNDER 1 YR. MONTHS DAYS	8. IF UNDER 24 HRS. HOURS MIN	2c. DATE PRONOUNCED DEAD				
Male	White	July 11, 1933	46 yrs.			9	3	19	79 M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH			
New Jersey		U.S.A.					Howard County, MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			11a. USUAL OCCUPATION (TYPE OF WORK)		11b. KIND OF BUSINESS OR INDUSTRY			
Columbia		Howard County General Hospital			Dep't Education		Howard County			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS		
Maryland		Howard		Ellicott City				10109 Century Drive		
14. FATHER'S NAME		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME		MIDDLE	LAST			
Late Salvatore		Fortunato		Ida						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.			17. INFORMANT		ADDRESS			
(If Yes, give war or dates)		143 24 5527			Mrs Norma Fortunato		10109 Century Drive			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: Arteriosclerotic Cardiovascular Disease										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
4292 IMMEDIATE CAUSE (a): DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last: (b) DUE TO, OR AS A CONSEQUENCE OF (c)										
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (d):										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?					
					<input checked="" type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART II)						
22a. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		22b. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		22c. LOCATION STREET		CITY OR TOWN	COUNTY	STATE		
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural cause <input checked="" type="checkbox"/> Accidents <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				Autopsy <input checked="" type="checkbox"/> Inspectio <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion:						
ACTUAL SIGNATURE										
EXAMINER'S NAME (TYPE OR PRINT)		Thomas D. Smith, M.D.		ADDRESS		TITLE (SPECIFY)			DATE SIGNED	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN		COUNTY	STATE	
Burial		Sept 6, 1979		Druid Ridge		Pikesville, Baltimore, Md.				
24. FUNERAL DIRECTOR NAME		Harry H. Witzke		COLUMBIA R'D		25a. DATE REC'D. BY REGISTRAR		25b. REGISTERED SIGNATURE		
		1112 Ellicott City				SEP 7 1979		Harry H. Witzke		

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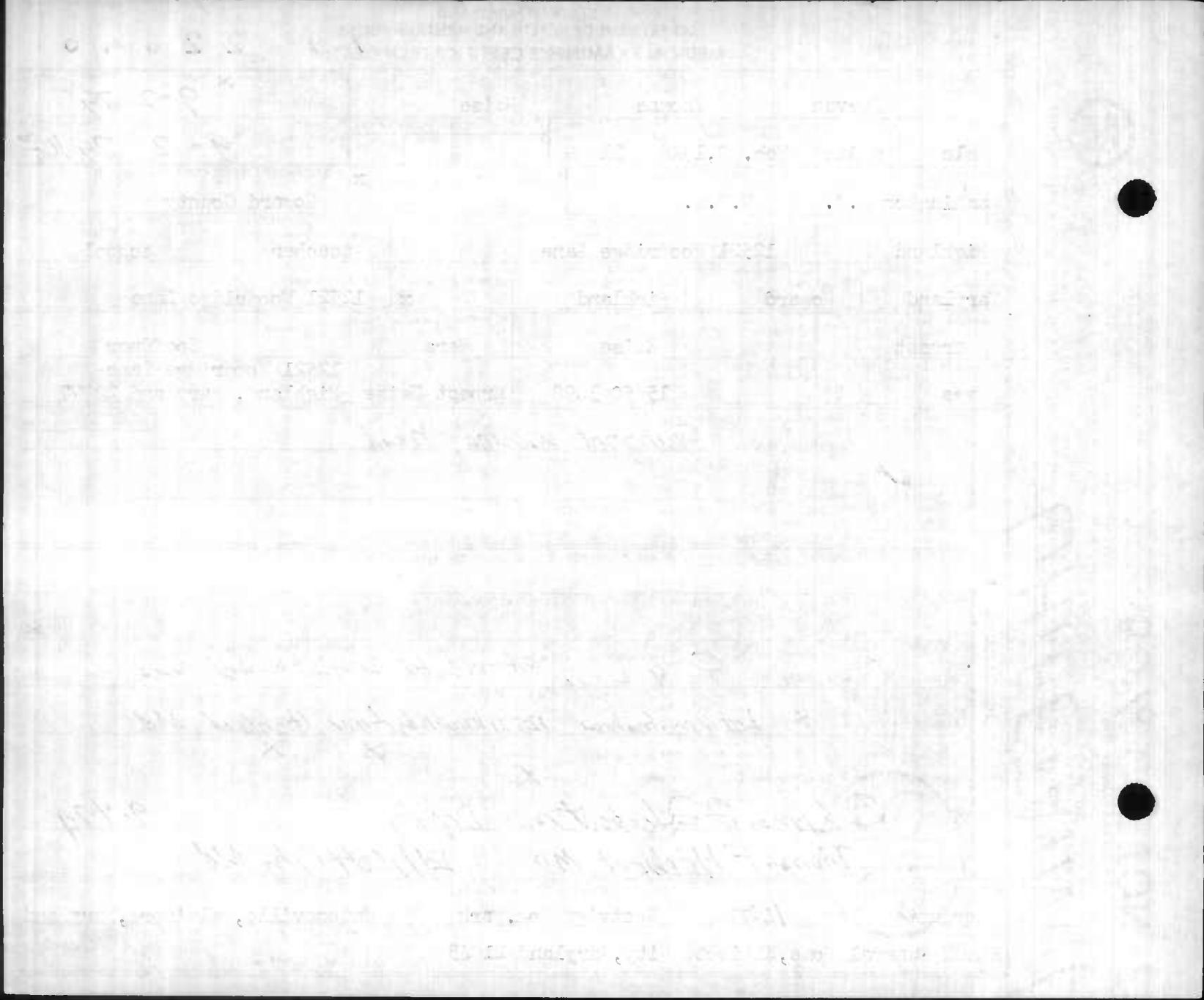
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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B, GIVE PAGES 1, 2, AND 3 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. RETAIN PAGE 4 FOR YOUR INFORMATION. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 22846	
1. DECEASED NAME (TYPE OR PRINT)			FIRST Steven	MIDDLE Thomas	LAST Heise	2a. DATE KNOWN OF DEATH ESTIMATED MATED			MONTH 9-2	DAY 1979	YEAR M
3. SEX male			4. RACE white	5. DATE OF BIRTH MONTH Feb.	DAY 8, 1948	YEAR 31	6. AGE (IN YEARS LAST BIRTHDAY) YRS. 31	IF UNDER 1 YR. MONTHS 0	IF UNDER 24 HRS. HOURS 0	MIN 0	2b. HOUR M
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington D.C.			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED WIDOWED DIVORCED			2c. DATE PRONOUNCED DEAD 9-2 1979		
10. CITY OR TOWN OF DEATH Highland			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 12521 Woodridge Lane			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) teacher			12b. KIND OF BUSINESS OR INDUSTRY school		
13a. STATE Maryland		13b. COUNTY Howard		13c. CITY OR TOWN Highland		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 12521 Woodridge Lane			
14. FATHER'S NAME FIRST Ernest			MIDDLE Heise			15. MOTHER'S MAIDEN NAME FIRST Vera			LAST Soeffner		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) yes			16b. SOCIAL SECURITY NO. ? 215 50 3098			17. INFORMANT Ernest Heise			12521 Woodridge Lane Highland, Maryland 20777		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 9554 IMMEDIATE CAUSE (a) <i>Gunshot wound, head</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)											
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?					
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 9-2 1979			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2) <i>Self-inflicted gunshot wound, head</i>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <i>Lot across from home</i>			21f. LOCATION STREET <i>12521 Woodridge Lane, Highland, Md.</i>			CITY OR TOWN COUNTY STATE		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <i>Thomas F. Herbert, M.D.</i>			TITLE (SPECIFY) <i>Deputy</i>			MEDICAL EXAMINER			DATE SIGNED 9-4-79		
EXAMINER'S NAME (TYPE OR PRINT) Thomas F. Herbert, M.D.			ADDRESS <i>Ellicott City, Md.</i>			23d. LOCATION CITY OR TOWN <i>Catonsville, Baltimore, Maryland</i>			COUNTY STATE		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) cremate			23b. DATE 9/4/79			23c. NAME OF CEMETERY OR CREMATORIAL Westview Mem. Park			23d. LOCATION CITY OR TOWN <i>Catonsville, Baltimore, Maryland</i>		
24. FUNERAL DIRECTOR NAME SLACK Funeral Home, Ellicott City, Maryland 21043			ADDRESS <i>Ellicott City, Maryland 21043</i>			25a. DATE REC'D. BY REGISTRAR SEP 5 1979			25b. REGISTRAR'S SIGNATURE <i>Victor McBrady</i>		

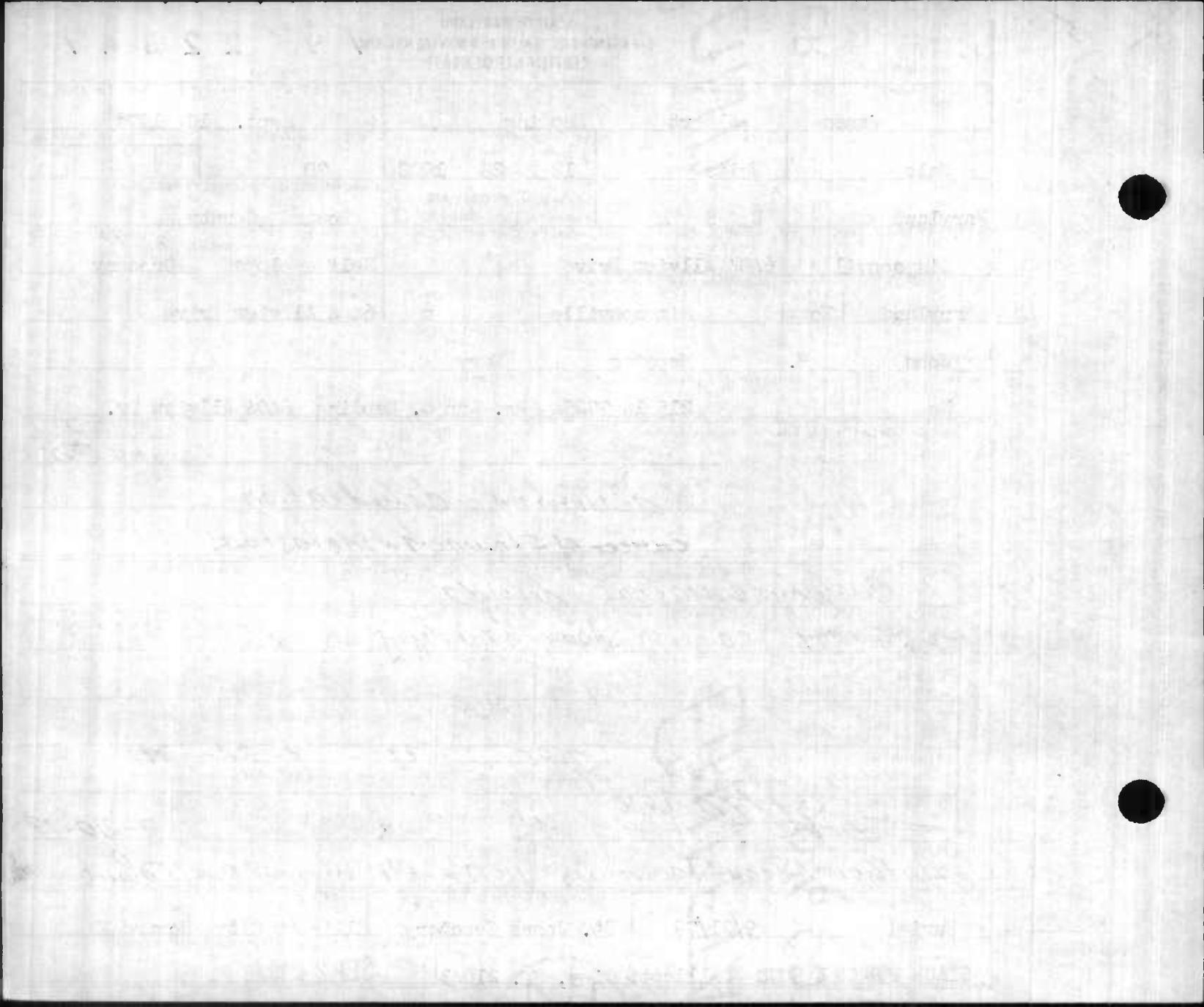


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 9 2 2 6 4 7							
1. FOR STATE REGISTRAR			FIRST			MIDDLE			LAST			2a. DATE OF DEATH Sept. 18 1979	MONTH	DAY	YEAR	2b. HOUR			
1. DECEASED NAME (TYPE OR PRINT)			James			Albert			Hedding										
3. SEX Male			4. RACE White			5. DATE OF BIRTH MONTH 12 DAY 28 YEAR 1908			6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS.			IF UNDER 1 YEAR MONTHS		IF UNDER 24 HRS DAYS HOURS MIN.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			7b. CITIZEN OF WHAT COUNTRY? U S A			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Howard County MD.										
10. CITY OR TOWN OF DEATH Simpsonville			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 6404 Allview Drive			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Self employed			12b. KIND OF BUSINESS OR INDUSTRY Grocery										
13a. STATE Maryland			13b. COUNTY Howard			13c. CITY OR TOWN Simpsonville			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS 6404 Allview Drive							
14. FATHER'S NAME FIRST John			MIDDLE H.			LAST Hedding			15. MOTHER'S MAIDEN NAME FIRST Mary			MIDDLE			LAST				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 215 14 7725a			17. INFORMANT Ms. Ann G. Hedding			ADDRESS 6404 Allview Dr.										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 months							
1519 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost												DUE TO, OR AS A CONSEQUENCE OF (b) <i>Malignant xeroderma & dehydration</i>							
												DUE TO, OR AS A CONSEQUENCE OF (c) <i>cancer of stomach & metastasis</i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Emphysema or lung</i>																			
19a. DATE OF OPERATION 7-26-1979			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>cancer of stomach bleeding</i>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>										
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE						
22a. I certify that (I) (this hospital) attended the deceased from 7-25-1979 to 8-24-1979, that (I) (we) last saw the deceased alive on 8-24-1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.															22c. DATE SIGNED 9-20-79				
22b. SIGNATURE <i>Anthony Jean-Jacques MD</i>			22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Anthony Jean-Jacques MD</i>			22e. DEGREE <i>MD</i>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 9/21/79			23c. NAME OF CEMETERY OR CREMATORIAL St. Johns Cemetery			23d. LOCATION CITY OR TOWN Ellicott City			COUNTY Howard		STATE MD.					
24. FUNERAL DIRECTOR NAME <i>SLACK FUNERAL HOME</i>			ADDRESS <i>Ellicott City, MD. 21043</i>			25a. DATE REC'D. BY REGISTRAR SEP 24 1979			25b. REGISTRAR'S SIGNATURE <i>Fenton McNamee</i>										

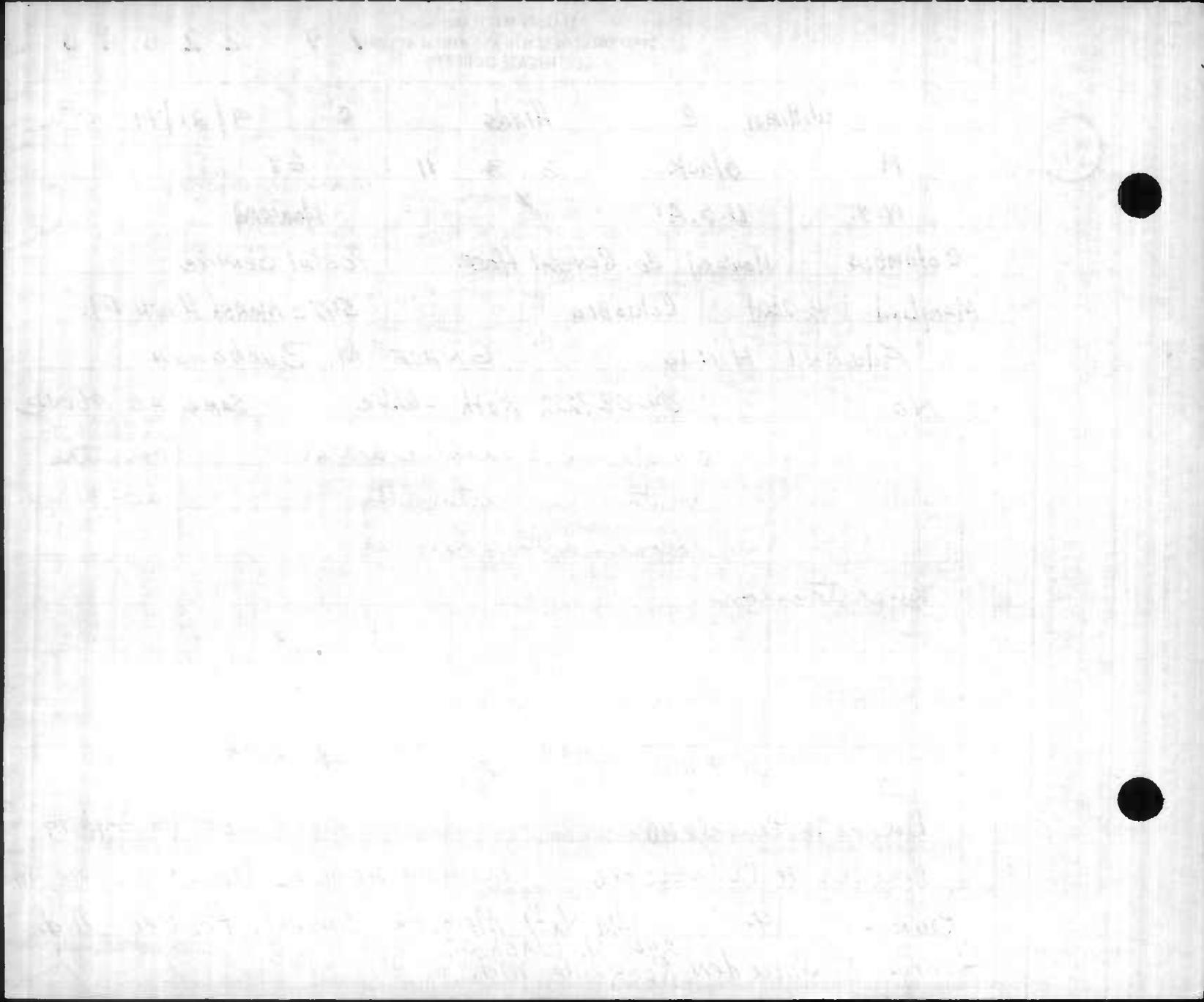


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. File 4 May by _____
retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Pages 1 and 2 should be detached for use on the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours of the death.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 7 9 2 2 3 4 8								
1. FOR STATE REGISTRAR			FIRST			MIDDLE			LAST			2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR				
1. DECEASED NAME (TYPE OR PRINT)			William E						Hinds			1	9	21	1979	5:45 a.m.				
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR			IF UNDER 24 HRS					
M			Black			MONTH 3 DAY 3 YEAR 11			68 YRS.			MONTHS			DAYS HOURS MIN.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8			MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
N.Y.			U.S.A.									Howard			Postal Service			M.D.		
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						13a. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Columbia			Howard Co. General Hosp.									5482 Marsh Hawk Rd.								
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			15. MOTHER'S MAIDEN NAME			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS		
Maryland			Howard			Columbia			Grace M. Buchanan						054-09 3222 Ruth - wife			same as above		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>arrhythmia & cardiac arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ventricular instability</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>coronary artery disease</u>															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u>					
															<u>20-30 yrs</u>					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Hypertension</u>																				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>												
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE										
22a. I certify that (I) (this hospital) attended the deceased from <u>MAY</u> , 19 <u>77</u> , to <u>present</u> , 19 <u> </u> , that (I) (we) last saw the deceased alive on <u>29 JUNE 19 77</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.												22b. DATE SIGNED <u>26 Sept 77</u>								
22b. SIGNATURE <u>Dolores M. Purnell MD</u>												ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>								
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Dolores M. Purnell MD</u>												22e. ADDRESS <u>COLUMBIA MEDICAL PLAN, COLUMBIA MD.</u>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL N. Wash. St.			23d. LOCATION CITY OR TOWN <u>LAUREL, Pa. Cem. Md.</u>			23e. COUNTIES			23f. STATE					
Burial			9-			Md. Nat'l Mem. Pk.														
24. FUNERAL DIRECTOR NAME <u>George R. Snowden</u>			ADDRESS <u>246 N. Wash. St. Rockville, Md.</u>			25a. DATE REC'D. BY REGISTRAR			25b. REPORTS MADE BY REGISTRAR											
						SEP 25 1979														



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD 'PENDING' IN PENCIL IN ITEM 1B, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR, PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR PERSONAL USE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 12 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET.

ITEMS #18a-22a Film G536 10/11/79 STATE OF MARYLAND FOR Item #5 Film G538 12/1/79 DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1- STATE REGISTRAR MEDICAL EXAMINER'S CERTIFICATE OF DEATH												2 2 8 4 9	
												REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF ESTI- DEATH MATED		MONTH	DAY	YEAR	1b. HOUR
RICHARD		R.		KEIM				<input type="checkbox"/>		9	15	1979	M
3. SEX	4 RACE	5. DATE OF BIRTH MONTH YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YR MONTHS DAYS	8. IF UNDER 24 HRS. HOURS MIN			2c. DATE PRONOUNCED DEAD		MONTH	DAY	YEAR	14. HOUR 9:54 P.M.
male	white	Dec. 21, 1955	23 yrs.					<input type="checkbox"/>		9	15	1979	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Howard County					
10. CITY OR TOWN OF DEATH Columbia		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Howard Co. General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Unemployed				12b. KIND OF BUSINESS OR INDUSTRY Unemployed					
13a. STATE Maryland		13b. COUNTY Howard		13c. CITY OR TOWN Ellicott City		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 9921 Carrigan Dr. Ellicott City					
14. FATHER'S NAME FIRST Alan G. Keim Sr.		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST Mable Bishop		MIDDLE		LAST			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO.		17. INFORMANT Alan G. Keim Sr. 9921 Carrigan Drive		ADDRESS							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Undetermined DUE TO, OR AS A CONSEQUENCE OF 7999 Conditions, if any, which gave rise to immediate cause (a) stating the <u>under-</u> lying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?									
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .												DATE SIGNED 9-16-79	
ACTUAL SIGNATURE <i>Anne M. Dixon</i>		EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D.		ADDRESS 111 Penn St.		TITLE (SPECIFY) M.D. Assistant		MEDICAL EXAMINER					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE Sept 18 1979		23c. NAME OF CEMETERY OR CREMATORIAL Westview		23d. LOCATION CITY OR TOWN Catonsville, Maryland		COUNTY		STATE			
24. FUNERAL DIRECTOR NAME Harry H. Witzke		ADDRESS 1112 Columbia Road Ellicott City		25a. DATE REC'D. BY REGISTRAR SFD 9 16 1979		25b. REGISTRAR'S SIGNATURE <i>Harry H. Witzke</i>							

NA

background

control condition

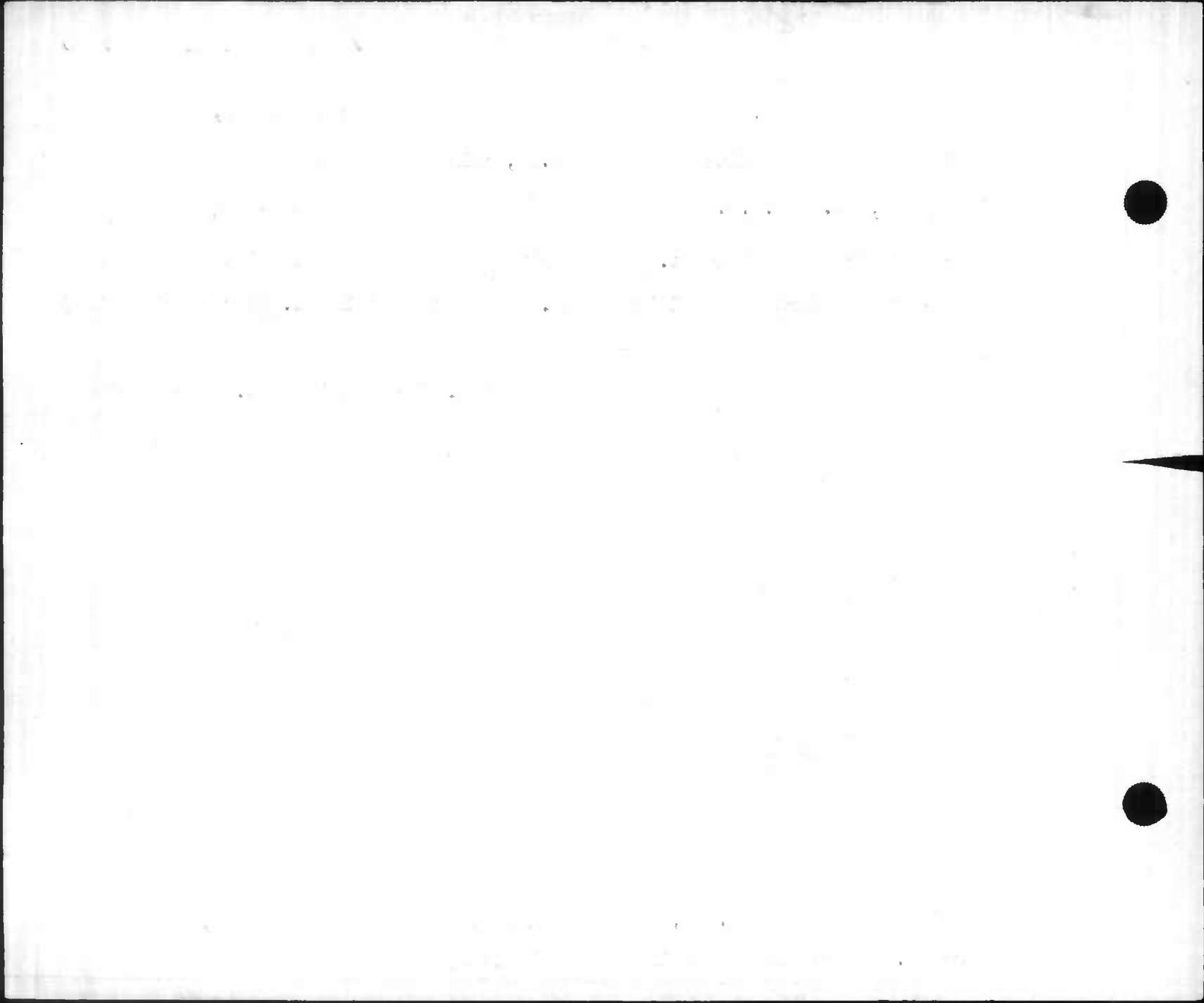
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be

repeated by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or either traumatic or nontraumatic, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						REG. NO. 19 22850			
1. FOR STATE REGISTRAR	FIRST	MIDDLE	LAST	2a DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR <u>10:30 AM</u>	
1. DECEASED NAME (TYPE OR PRINT)	MARIE A. KLEMMSEN				September 13, 1979				
3. SEX <u>F</u> emale	4 RACE <u>White</u>	5. DATE OF BIRTH <u>Sept. 19, 1913</u>			6 AGE (IN YEARS LAST BIRTHDAY) <u>65</u>	IF UNDER 1 YEAR <u>YRS.</u>	IF UNDER 4 HRS <u>MONTHS</u>	2b. HOUR <u>10:30 AM</u>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Baltimore, Md.</u>	7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <u>Howard County</u>				
10. CITY OR TOWN OF DEATH <u>Ellicott City</u>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>2414 Mt. Hebron Drive</u>					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Housewife</u>			
13a. STATE <u>Maryland</u>	13b. COUNTY <u>Howard</u>	13c. CITY OR TOWN <u>Ellicott Cty</u>	13d. INSIDE CITY LIMITS? <u>YES</u> <input type="checkbox"/> <u>NO</u> <input checked="" type="checkbox"/>		13e. STREET ADDRESS <u>2414 Mt. Hebron Drive 21043</u>				
14. FATHER'S NAME <u>late</u>	FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME <u>Floegel</u>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>NO</u>	16b. SOCIAL SECURITY NO.			17. INFORMANT <u>Paul D. Klemmsen</u>				ADDRESS <u>2414 Mt. Hebron Drive</u>	
18. CAUSE OF DEATH (Enter only one cause per line for 18a, 18b, and 18c.) PART 1. DEATH WAS CAUSED BY <u>1539</u> IMMEDIATE CAUSE (a) <u>Untestable cause of colon</u> APPROXIMATE INTERVAL BETWEEN DEATH AND DEATH <u>272 min</u>									
DUE TO, OR AS A CONSEQUENCE OF (b) _____									
DUE TO, OR AS A CONSEQUENCE OF (c) _____									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a). _____									
19a. DATE OF OPERATION <u> </u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u> </u>				20a. AUTOPSY? <u>NO</u> <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? <u>NO</u> <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <u>19</u>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) <u> </u>						
21d. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <u> </u>	21f. LOCATION STREET <u> </u>		CITY OR TOWN <u> </u>	COUNTY <u> </u>	STATE <u> </u>		
22a. I certify that (I) <u>the deceased</u> died the deceased from <u>Jane 1969 to 9/13 1979</u> , that (I) <u>was</u> last seen the deceased alive on <u>9/13 1979</u> , and that in (my) <u> </u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>did</u> (I) <u>did not</u> view the body after death.									
22b. SIGNATURE <u> </u>		DEGREE <u> </u>	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <u>9/16/79</u>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u> </u>		22e. ADDRESS <u> </u>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>Sept. 17, 1979</u>	23c. NAME OF CEMETERY OR CREMATORIAL <u>Crestlawn</u>	23d. LOCATION CITY OR TOWN <u> </u>	23e. COUNTY <u> </u>	23f. STATE <u> </u>			
24. FUNERAL DIRECTOR <u>Harry H. Witzke</u>		ADDRESS <u>4112 Columbia Road Ellicott Cty</u>	25a. DATE REC'D. BY REGISTRAR <u>SEP 18 1979</u>		25b. REGISTRAR'S SIGNATURE <u>Lester Balow</u>				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director it should be detached for use as the burial transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO.						
1 - STATE REGISTRAR			2a DATE OF DEATH MONTH DAY YEAR									2b HOUR						
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	Sept. 10, 1979									3:15 AM			
2. SEX			3 RACE	5. DATE OF BIRTH MONTH DAY YEAR			6 AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS						
Female			Black	July 9, 1934			45			MONTHS	DAYS	HOURS	MIN.					
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b CITIZEN OF WHAT COUNTRY?			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH			MD.						
Balto.. Md.			U. S. A.			WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			Howard County,									
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)									12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b KIND OF BUSINESS OR INDUSTRY			
Columbia, Md.			Howard County General Hospital									Director			American Pre-School Center.			
13a STATE			13b COUNTY			13c CITY OR TOWN			13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e STREET ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
Maryland			Howard			Columbia			NO			5034 Broken Oak Lane			2 days			
14 FATHER'S NAME			FIRST	MIDDLE	LAST	15 MOTHER'S MAIDEN NAME			FIRST	MIDDLE	LAST							
Leonard C. Thomas						Della					Morton							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b SOCIAL SECURITY NO.			17 INFORMANT			ADDRESS									
no			212 34 3206			Dr. Daniel Robertson			5034 Broken Oak									
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIOVASCULAR COLLAPSE</u> 430- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.													2 days					
DUE TO, OR AS A CONSEQUENCE OF (b) <u>PROBABLE INTRACEREBRAL HEMORRHAGE WITH BRAIN STEM DESTRUCTION</u>													2 days					
DUE TO, OR AS A CONSEQUENCE OF (c) <u>MALIGNANT HYPERTENSION - HYPERTENSIVE CRISIS</u>													2 days					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>HYPERTENSION OF 2-3 YEARS DURATION</u>																		
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED						20a AUTOPSY?			20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?						
									YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)												
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE												
22a I certify that (I) (this hospital) attended the deceased from <u>9/7</u> 19 <u>79</u> to <u>9/10</u> 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>9/10</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																		
22b. SIGNATURE <u>John J. Blanch</u> DEGREE <u>MD</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>													22c. DATE SIGNED <u>9/10/79</u>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>JOHN J. BLANCH, MD</u>			22e. ADDRESS <u>PATUXENT MEDICAL GROUP 5999 HARPERS FARM RD COLUMBIA, MD 21046</u>															
23a BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE <u>9/13/79</u>			23c NAME OF CEMETERY OR CREMATORIALy			23d. LOCATION CITY OR TOWN <u>Laurel</u> COUNTY <u>Md.</u> STATE									
Burial						Md. National Mem.												
24. FUNERAL DIRECTOR NAME <u>James A. Morton & Son</u>			ADDRESS <u>1701 Laurens St.</u>			25a. DATE REC'D. BY REGISTRAR <u>SEP 13 1979</u>			25b. MEDICAL EXAMINER'S SIGNATURE <u>Henry McCreary</u>									

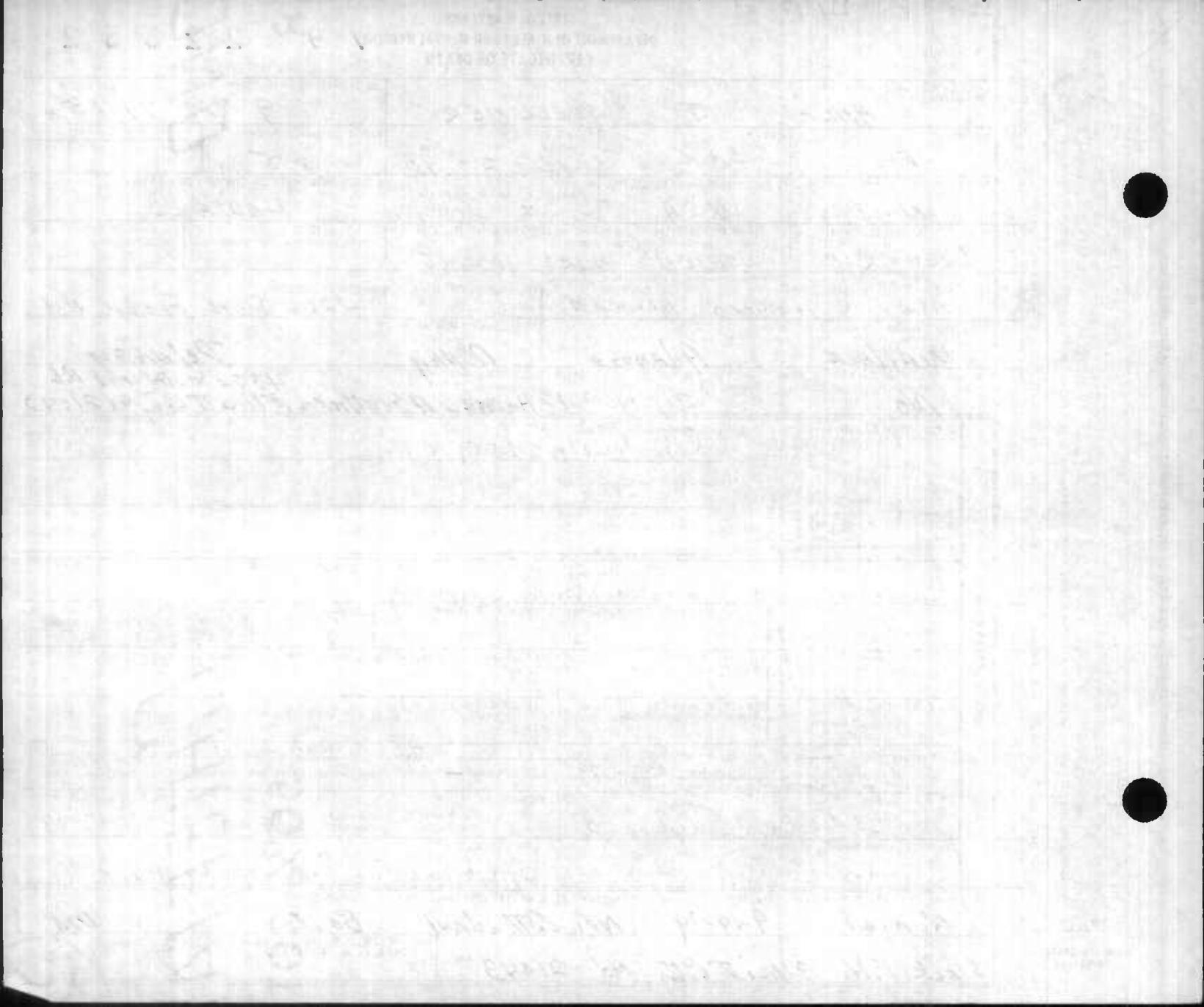
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-trust permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 7 9 2 2 8 5 2			
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR			
ANNA J. SOELLNER						9 17 79						135 PM			
3 SEX F		4 RACE CAUC.		5. DATE OF BIRTH MONTH DAY YEAR 10 - 2 - 93			6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE COUNTRY N.J.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH HOWARD MD.								
10. CITY OR TOWN OF DEATH COLUMBIA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) LORIEN NURS. HOME		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY								
13a. STATE MD		13b. COUNTY HOWARD		13c. CITY OR TOWN ELLICOTT			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 4206 South Field Rd.					
14. FATHER'S NAME WILLACE		FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME Adams			16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			17. INFORMANT 213-74-7616 Andrew A. Soellner			ADDRESS 4206 South Field Rd. RE ELLICOTT CITY MD 21043		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Obstructive lung disease 496- DUE TO, OR AS A CONSEQUENCE OF (b) Conditions, if any, which goes rise to immediate cause (a), stating the underlying cause lost. { DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH years			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Carcinoma of parotid gland. Suspected															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE										
22a. I certify that (I) (this hospital) attended the deceased from 19 74 to September 17, 19 79, that (I) (we) lost saw the deceased alive on September 13 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.												22c. DATE SIGNED 9-17-79			
22b. SIGNATURE Charles E. Taylor		22d. DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>										
22e. PHYSICIAN'S NAME (TYPE OR PRINT) Charles E. Taylor MD		22f. ADDRESS 5999 Harper's Farm Rd. Columbia MD 21043													
23a. BURIAL, CREMATION, REMOVAL (SPECIES) Burial		23b. DATE 9-19-79		23c. NAME OF CEMETERY OR CREMATORIAL New Bethesda			23d. LOCATION CITY OR TOWN Ba 170,			COUNTY		STATE Md.			
24. FUNERAL DIRECTOR NAME Slack F.H. Ellicott City MD 21043		ADDRESS			25a. DATE REG'D BY REGISTRAR SEP 24 1979			25b. REGISTRAR'S SIGNATURE John Kennedy							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 7 9 2 2 8 5 3		
1. FOR - STATE REGISTRAR			2a. DATE OF DEATH Sept. 18 1979			2b. HOUR M						
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST							
Edmund Augustus Sullivan												
3. SEX M			4 RACE White	5. DATE OF BIRTH MONTH July DAY 9 YEAR 1898			6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS.					
							IF UNDER 1 YEAR MONTHS 0 DAYS HOURS 0 MIN					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Hampshire			7b. CITIZEN OF WHAT COUNTRY? U S A			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Howard County MD.			
10. CITY OR TOWN OF DEATH Ellicott City			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 12142 Tridelphia Road			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Attorney			12b. KIND OF BUSINESS OR INDUSTRY Self Employ			
13a. STATE Maryland			13b. COUNTY Howard	13c. CITY OR TOWN Ellicott City			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS 12142 Tridelphia Road		
14. FATHER'S NAME FIRST John			MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST Elizabeth MIDDLE LAST Fitzgerald			ADDRESS				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 023 07 2864			17. INFORMANT Martha Sabus			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH MINUTES			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest			DUE TO, OR AS A CONSEQUENCE OF (b) Cor pulmonale						142			
496- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			DUE TO, OR AS A CONSEQUENCE OF (c) C.O.P.D.						10yrs			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Cerebral Atherosclerosis, arteritis												
19a. DATE OF OPERATION -			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED -			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. - 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET - CITY OR TOWN - COUNTY - STATE -						
22a. I certify that (I) (this hospital) attended the deceased from 9/78 19 to 9/18 1979, that (we) last saw the deceased alive on 9/78 19, and that is (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.												
22b. SIGNATURE Edmund Kordon			22c. DEGREE MELVIN J Kordon MELVIN			ATTENDING MEDICAL STAFF PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 9/18/79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MELVIN J Kordon MELVIN			22e. ADDRESS 20th Century Plaza Columbia Md.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 9/20/79			23c. NAME OF CEMETERY OR CREMATORIAL Holy Cross Cemetery			23d. LOCATION CITY OR TOWN Malden COUNTY Middlesex STATE Mass.			
24. FUNERAL DIRECTOR NAME SLACK FUNERAL HOME			ADDRESS Ellicott City 3871 Columbia Rd. 21043			25a. DATE REC'D. BY REGISTRAR SEP 24 1979			25b. REGISTRAR'S SIGNATURE Mary McCreedy			

Two hours

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, should be detached for use as the burial/tranit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												9	2	2	8	5	4
												REG. NO. 22854					
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR					
Edwin Edwin M. Taylor Sr. Taylor						9			1	79	4:00 P.M.						
3. SEX			4. RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS					
M			Cauc.	August 16, 1923			56			MONTHS	DAYS	HOURS	MIN				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8			9 BALTIMORE CITY OR COUNTY OF DEATH								
Pennsylvania			U.S.A.			MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			Howard County								
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY								
Columbia			Howard County General Hospital														
13a. STATE			13b. COUNTY	13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS							
Maryland			Howard	Columbia						8852 H Spiral Cut Columbia Md.							
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME											
Clifton M Taylor						Helen Moats											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS								
No			191 18 7621			Mrs Onada H Taylor			8852 H Spiral Cut								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY:			IMMEDIATE CAUSE (a) <i>Cardiopulmonary arrest</i>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Minutes</i>								
			DUE TO, OR AS A CONSEQUENCE OF (b) <i>Congestive heart failure</i>						<i>Months</i>								
			DUE TO, OR AS A CONSEQUENCE OF (c) <i>Coronary artery disease</i>						<i>Years</i>								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: <i>Fever and shock - dehydration</i>																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE						
22a. I certify that (I) (this hospital) attended the deceased from <i>8/31</i> , 19 <i>79</i> , to <i>9/1</i> , 19 <i>79</i> , that (we) lost saw the deceased alive on <i>9/1/79</i> , 19 <i>79</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE						DEGREE			21g. DATE SIGNED <i>9/1/79</i>								
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			23e. COUNTY		STATE			
Burial			Sept 5, 1979			Meadowsidge						Howard, Maryland					
24. FUNERAL DIRECTOR NAME			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE											
Harry H. Witzke 4112 Columbia Road Ellicott City			SEP 7 1979														

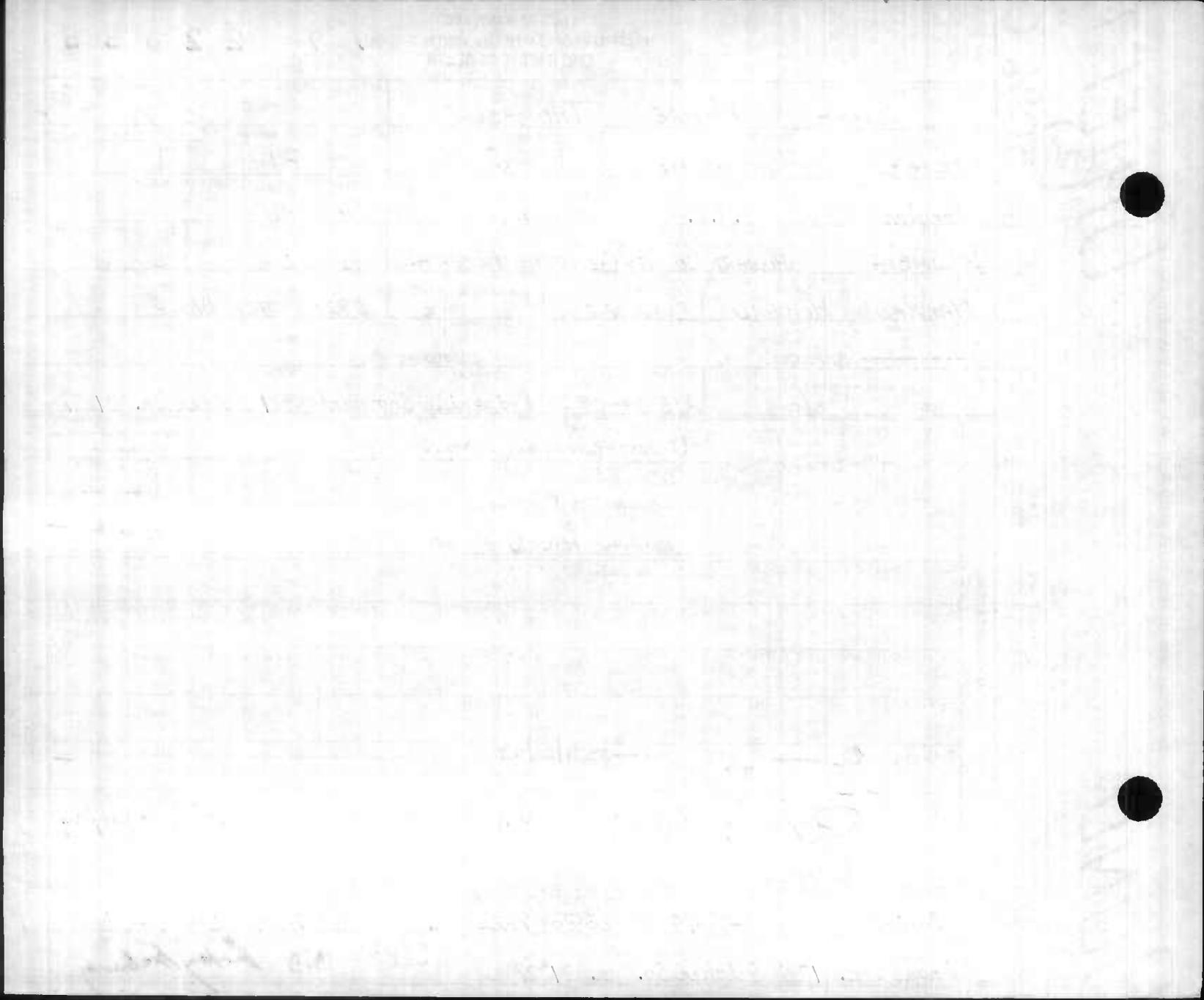
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examination must be completed at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH																				
REG. NO. 7 9 2 2 8 5 5																				
1 - FOR STATE REGISTRAR																				
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR		
EMMA			MOORE			THOMPSON						9 20 79					4:57 PM			
3. SEX			4 RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)						IF UNDER 1 YEAR		IF UNDER 24 HRS			
Female			Caucasian			MONTH 8 DAY 30 YEAR 98			81						MONTHS		DAYS		HOURS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			Howard			YRS.		HRS.			
Maryland			U.S.A.																	
11. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY											
COLUMBIA			HOWARD COUNTY GENERAL HOSPITAL			Housewife			own home											
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS								
MARYLAND			HOWARD			ELKRIDGE						5921 SETTER DRIVE								
14. FATHER'S NAME			FIRST			MIDDLE			LAST			15. MOTHER'S MAIDEN NAME			FIRST		MIDDLE			
unknown												unknown								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS											
no			n/a			215-54-0821			Catherine Shoppert			5921 Setter Dr. 21227								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cordropulmonary arrest</i>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>minutes</i>								
2500 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>infarction MI</i> (c) <i>severe myocard 20 DM</i>												<i>hours</i>								
DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF												<i>years</i>								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																				
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?											
						YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IE EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)														
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY								
22a. I certify that <i>I</i> (we) attended the deceased from on <i>9/20/79</i> , 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on <i>9/20/79</i> , 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						DEGREE						STATE:								
22b. SIGNATURE <i>Bonny (PAUL)</i>						ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						22c. DATE SIGNED <i>9/20/79</i>								
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>D. PAUL</i>						22e. ADDRESS														
23a. BURIAL, CREMATION, REMOVAL (SPECIES)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			COUNTY								
Burial			9-24-79			Loudon Park Cem.			Baltimore City			Maryland								
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE											
Ambrose Inc. 1328 Sulphur Sp. Rd. 21227						SEP 24 1979			<i>Hanley Ambrose</i>											

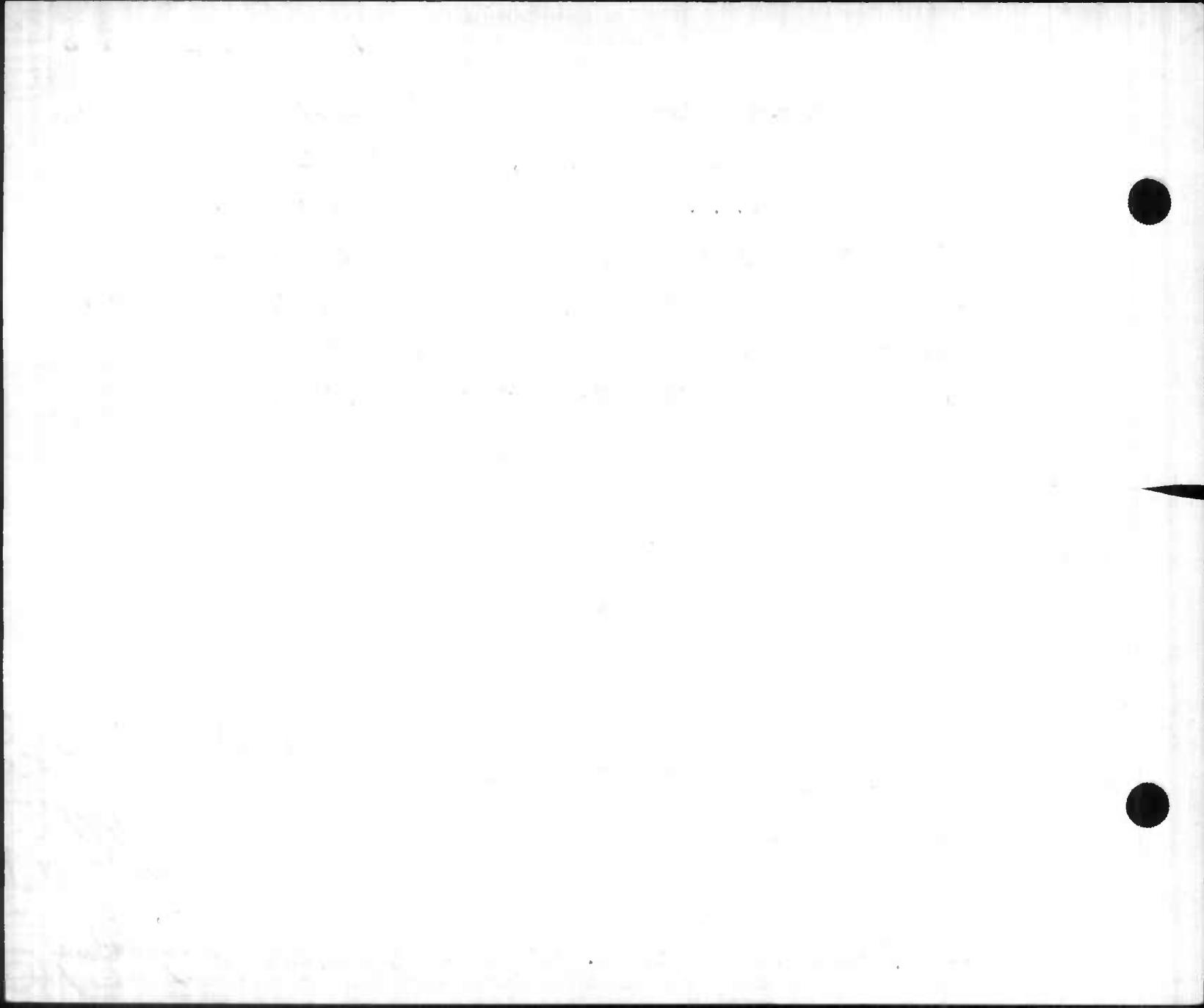


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, or by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death, with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked for any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 19 22856	
1 - STATE REGISTRAR			2a DATE OF DEATH MONTH DAY YEAR							2b HOUR	
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			Sept. 8, 1979			6:20 A.M.		
Linwood R Uhler											
3. SEX		4 RACE		5. DATE OF BIRTH MONTH DAY YEAR			6 AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR IF UNDER 24 HRS	
Male		White		July 17, 1908			71			MONTHS DAYS HOURS MIN	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH Howard County			MD.	
10 CITY OR TOWN OF DEATH Ellicott City		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 8910 Wilton Ave		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired Transit			12b. KIND OF BUSINESS OR INDUSTRY Adm				
13a. STATE Maryland		13b. COUNTY Howard		13c. CITY OR TOWN Ellicott City			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 8910 Wilton Ave Ellicott City	
14 FATHER'S NAME late William H Uhler				15 MOTHER'S MAIDEN NAME late Laura B Raver							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO 213 05 9150		17 INFORMANT Doris Uhler 8910 Wilton Ave			ADDRESS				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 410- Conditions, if any, which give rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) CHF, hypertension										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 0 6 mo 7 yrs	
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET		CITY OR TOWN		COUNTY	STATE	
22a I certify that (I) (this hospital) attended the deceased from <u>Sept 7, 1979</u> to <u>Sept 8, 1979</u> , and that in (my) <input type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input type="checkbox"/> did <input type="checkbox"/> view the body after death.										22b. DATE SIGNED 9/9/79	
22b. SIGNATURE <i>J. Nelson McRoy, MD</i>			DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. ADDRESS 1132 N. Rolling Rd., Beltsville, Md. 20705					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) J. Nelson McRoy, MD											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Sept 11, 1979		23c. NAME OF CEMETERY OR CREMATORIAL Meadowridge			23d. LOCATION CITY OR TOWN Howard, Maryland			
24 FUNERAL DIRECTOR NAME Harry H. Witzke 4112 Columbia Rd. Ellicott City						25a. DATE REC'D. BY REGISTRAR SEP 13 1979			25b. REGISTRAR'S SIGNATURE <i>Hector McRoy</i>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-trust permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 9 2 2 8 5 7	
1. FOR STATE REGISTRAR			2a. DATE OF DEATH Sept. 26, 1979							2b. HOUR 9:05 AM	
1. DECEASED NAME (TYPE OR PRINT)	FIRST Frank		MIDDLE J.		LAST WALL			6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
3 SEX Male	4 RACE White		5. DATE OF BIRTH MONTH March DAY 29, YEAR 1894								
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Conn.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					9. BALTIMORE CITY OR COUNTY OF DEATH Howard Co., MD.			
10. CITY OR TOWN OF DEATH Columbia	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Howard County General Hospital		12a. USUAL OCCUPATION Police Commissioner		12b. KIND OF BUSINESS OR INDUSTRY						
13a. STATE Maryland	13b. COUNTY Howard	13c. CITY OR TOWN Woodbine		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 15930 A.E. Mullinix Rd.					
14. FATHER'S NAME FIRST John	MIDDLE H.	LAST Wall		15. MOTHER'S MAIDEN NAME FIRST Catherine		MIDDLE	LAST Breareton				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes	16b. SOCIAL SECURITY NO. W.W. 1		17. INFORMANT Mary A. Heller, Item 13		ADDRESS						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4289										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) DUE TO, OR AS A CONSEQUENCE OF HEART FAILURE											
DUE TO, OR AS A CONSEQUENCE OF (c) HEART FAILURE											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) POSSIBLE SEPTICemia; POSSIBLE GI BLEED; URINARY TRACT INFECTION											
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from 12-28-1979, to 9-25-1979, that (I) (we) last saw the deceased alive on 9-25-1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										22c. DATE SIGNED	
22b. SIGNATURE A. Sidhu, M.D.										22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Ajai S. Sidhu, M.D.										22e. ADDRESS 9380 Baltimore National Pike, Ellicott City, Md.	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation	23b. DATE Sept. 27, 1979		23c. NAME OF CEMETERY OR CREMATORIAL Westview		23d. LOCATION CITY OR TOWN Baltimore, Md.						
24. FUNERAL DIRECTOR NAME Olin L. Molesworth, Damascus, Md.	ADDRESS		25a. DATE REC'D. BY REGISTRAR SEP 28 1979		25b. REGISTRAR'S SIGNATURE						

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the death. Please
relinquish by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after
with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 9 22858			
1 - FOR STATE REGISTRAR															
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR			
Mary			Wright			9/27/79						3:25 AM			
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS	
Female			White			Jan 24, 1905			74			MONTHS		DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8			MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			
Maryland			U.S.A.									Howard County			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS			12b. KIND OF BUSINESS OR INDUSTRY			
Howard County			Howard County Gen. Hospital						1670 Woodstock Road 21163			Homemaker			
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS			
Maryland			Howard			Woodstock						1670 Woodstock Road 21163			
14. FATHER'S NAME			FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME									
Martin J. Antkowiak						Rose Czarniecki									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, OR UNKNOWN) (IF			17. INFORMANT			Mr. Philip L. Wright			ADDRESS			
No			217-07-0026A			1670 Woodstock Road			Woodstock, Md. 21163						
18. CAUSE OF DEATH (Enter only one cause per line for item 18b and 18c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (10):															
Cardiac arrest last															
3989 Conditions, if any, which gave rise to immediate cause (10), stating the underlying cause (last).															
DUE TO, OR AS A CONSEQUENCE OF (b) Suggestion of failure 5 + years															
DUE TO, OR AS A CONSEQUENCE OF (c) Sugg. last. dis. 2															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 10															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?						
									YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET _____ CITY OR TOWN _____ COUNTY _____ STATE _____									
22a. I certify that (I) this hospital attended the deceased from <u>9/26</u> to <u>9/27</u> , 19 <u>79</u> , and that in my opinion death occurred on the date and hour and from the causes stated saw the deceased alive on <u>9/26</u> 19 <u>79</u> , and that in my opinion death occurred on the date and hour and from the causes stated above, (I) did not allow the body to be viewed after death.															
22b. SIGNATURE			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED						
Dr. Christian S. Moss									9/27/79						
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS			3459 South John Lane 21043						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN _____ COUNTY _____ STATE _____						
Burial			10/1/79			St. Alphonsus Cem.			Woodstock						
24. FUNERAL DIRECTOR NAME			Loring Byers Funeral Directors, P.A.			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE						
8728 Liberty Road			Randallstown, Maryland 21133			SEP 28 1979			Henry Kennedy						

